COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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July 16, 2004

Mary T. McSorley
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
Suite 216, The Public Ledger Building
150 South Independence Mall,West
Philadelphia, PA 19106-3499

Dear Ms. McSorley:

Please find enclosed Virginia's Application to amend the Consumer-Directed Personal Assistance Services (CDPAS) Waiver (0321). The Department of Medical Assistance Services (DMAS) is requesting to rename the waiver and call it the Elderly or Disabled with Consumer Direction Waiver (EDCD) Home and Community-Based 1915 (c) Waiver. DMAS is also requesting that this waiver combine the services of Virginia's Elderly and Disabled (E&D) Waiver (waiver number 48.90.R3.01) with the CDPAS Waiver. The EDCD Waiver will include consumer directed and agency-directed personal assistance services, respite care, adult day health care, and personal emergency response systems. In addition, DMAS would like to add consumer-directed respite care. We appreciate your review of this waiver revision and are requesting a retroactive effective date of July 1, 2004.

We anticipate that Virginia's EDCD Waiver will provide much needed home and community-based care to persons who would otherwise require nursing facility care. With this revision, DMAS is requesting the current E&D Waiver be discontinued on the effective date the EDCD waiver is approved.

Also please find Virginia's revised response to questions posed by CMS that pertain to funding sources for Medicaid waiver payments (Attachment 1).

We look forward to your review of the enclosed waiver application. Please contact Ms. Karen Lawson, of my staff at (804) 225-2536 or by e-mail at Karen.Lawson@dmas.virginia.gov if you have any questions.

Sincerely,

Patrick W. Finnerty

PWF/vwh
Enclosures

Attachment 1
Medicaid Waiver Payments

Question #1: Do Home and Community Base Services providers retain all of the Medicaid payments (including regular and any supplemental payments)?

DMAS Response: Yes, the providers retain 100% of both the federal and state Medicaid payment provided for rendering EDCD Waiver services.

Question #2: Please describe how the state share of each type of Medicaid payment in the financial estimates provided in the waiver (including regular and any supplemental payments) is funded.

DMAS Response: All Medicaid payments for EDCD waiver services are made by DMAS. The state share for Medicaid payment is appropriated by the General Assembly as state general funding. There are no intergovernmental transfer agreements, certified public expenditures, or other mechanisms available for EDCD Waiver funding. For State Fiscal Year (SFY) 2004, Virginia's original state share was 49.87%. Due to the enhanced federal matching funds provided by the Jobs and Growth Tax Relief Act of 2003 (H.R. 2), Virginia's new state match rate for SFY 2004 is 46.29%. All federal matching funds are used to make payment for services provided in the EDCD Waiver.

Question #3**:** If supplemental or enhanced payments are made for services under an approved State plan/waiver, please provide the total amount for each type of supplemental or enhanced payment made to each provider type in the waiver.

DMAS Response: There are no supplemental payments made to providers for the provision of EDCD Waiver services.

Question #4: Does any public provider receive payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing services?

DMAS Response: No EDCD Waiver public provider receives payments for waiver services that (in the aggregate) exceeded its reasonable costs of providing services.

Elderly or Disabled with Consumer-Direction Home and Community-Based 1915 (c) Waiver Application

Waiver Number 0321: Amendment to the Consumer-Directed Personal Attendant Services Waiver

Submitted July 16, 2004

The Commonwealth of Virginia
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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SECTION 1915(c) WAIVER REQUEST

1. The State of Virginia requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.
This is a request for a model waiver.
a.____ Yes b. XX No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):
a.____ 3 years (initial waiver) b. XX 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:
a. XX Nursing facility (NF)
b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)
c.___ Hospital
d.___ NF (served in hospital)
e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:
a.____ aged (age 65 and older)
b.____ disabled
c. XX aged and disabled
d.____ mentally retarded
e.____ developmentally disabled
f.____ mentally retarded and developmentally disabled
g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
a.____ Waiver services are limited to the following age groups (specify):
b.____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
d.____ Other criteria. (Specify):
e. XX Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.
a. XX Yes b.____ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
a. XX Yes b. ___ _ No c.____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
a.____ Yes b. XX No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.
a..____ Yes b. XX No
If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.___ Case management
b.____ Homemaker
c.____ Home health aide services
d. XX Personal care services (agency and consumer directed)
e. XX Respite care (agency and consumer-directed)
f. XX Adult day health
g.____ Habilitation
____ Residential habilitation
____ Day habilitation
____ Prevocational services
____ Supported employment services
____ Educational services
h.____ Environmental accessibility adaptations
i.____ Skilled nursing
j.____ Transportation
k. Specialized medical equipment and supplies
l.____ Chore services

m. XX Personal Emergency Response Systems
n.____ Companion services
o.____ Private duty nursing
p.____ Family training
q.____ Attendant care
r.____ Adult Residential Care
____ Adult foster care
____ Assisted living
s.____ Extended State plan services (Check all that apply):
____ Physician services
____ Home health care services
____ Physical therapy services
____ Occupational therapy services
____ Speech, hearing and language services
____ Prescribed drugs
____ Other (specify):
t.____ Other services (specify):
u.____ The following services will be provided to individuals with chronic mental illness:
____ Day treatment/Partial hospitalization
____ Psychosocial rehabilitation
____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR) or who are residents of an assisted living facility (ALF).

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. XX When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
b. XX Meals furnished as part of a program of adult day health services.
c.____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be

reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and
2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. XX Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ____ Yes b. XX No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2004 is requested.

20. The State contact person for this request is Karen Lawson, who can be reached by telephone at (804) 225-2536 .

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's

authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
Print Name: Patrick W. Finnerty
Title: Director
Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_XX_ The waiver will be operated directly by the Waiver Services Unit of the Medicaid agency.

____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. ___Case Management:

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.
Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

___ Other Service Definition (Specify):

b. Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d. XX Personal assistance services:

_XX_ Providing assistance with Activities of Daily Living (ADLs): eating, bathing, dressing, transferring, and toileting, it includes medication monitoring and monitoring health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-20-420 through 18VAC90-20-460. When specified in the plan of care, personal assistance services may include assistance with Instrumental Activities of Daily Living (IADLs), such as bedmaking, dusting, vacuuming, shopping and preparation of meals, but does not include the cost of the meals themselves. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's family. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. Provision of these services is not limited to the home.

An additional component to personal assistance is work- or school-related personal assistance. This allows the personal assistance provider to provide assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who also require personal assistance services to meet their ADLs. Workplace or school supports through the Elderly or Disabled with Consumer-Direction Waiver are not provided if they are services provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act.

This service is agency-directed and consumer-directed. Please refer to Exhibit A for an overview of the consumer-directed model of this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

XX Personal assistance providers may be members of the individual's family. Payment will not be made for services furnished by spouses or parents of minor children. Payment will not be made for services furnished by other family members living under the same roof with the individual unless there is objective written documentation as to why there are no other providers available to provide the care.

Justification attached. (Check one):

XX Family members who provide personal assistance services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal assistance services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal assistance providers will be furnished by (Check all that apply):

XX A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

3. Frequency or intensity of supervision (Check one):

____ As indicated in the plan of care

_XX Other (Specify):

The agency RN supervisor shall make supervisory visits as often as needed, but no fewer visits than provided as follows, to ensure both quality and appropriateness of services.

(1) A minimum frequency of these visits is every 30 days for recipients with a cognitive impairment and every 90 days for recipients who do not have a cognitive impairment.

(2) Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, problem solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, or impulse control.

(3) The initial home assessment visit by the RN shall be conducted to create the plan of care and assess the recipient's needs. The RN shall return for a follow-up visit within 30 days after the initial visit to assess the recipient's needs and make a final determination that there is no cognitive impairment. This determination must be documented in the recipient's record by the RN. Recipients who are determined to have a cognitive impairment will continue to have supervisory visits every 30 days.

(4) If there is no cognitive impairment, the RN may give the recipient or caregiver the option of having the supervisory visit every 90 days or any increment in between, not to exceed 90 days. The RN must document in the recipient's record this conversation and the option that was chosen.

(5) The provider agency has the responsibility of determining if 30-day RN supervisory visits are appropriate for the recipient. The provider agency may offer the extended RN visits, or the agency may choose to continue the 30-day supervisory visits based on the needs of the individual. The decision must be documented in the recipient's record.

If a recipient's personal assistant is supervised by the provider's RN less often than every 30 days and DMAS or the designated preauthorization contractor determines that the recipient's health, safety, or welfare is in jeopardy, DMAS, or the designated preauthorization contractor, may require the provider's RN to supervise the personal assistant every 30 days or more frequently than what has been determined by the RN. This will be documented and entered in the recipient's record.

4. Relationship to State plan services (Check one):

XX Personal assistance services are not provided under the approved State plan.

___ Personal assistance services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal assistance services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

____ Other service definition (Specify):

e. XX Respite care:

XX Services provided in the home and community to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. Respite care provided in any setting shall be limited to a total of 720 hours per recipient per calendar year. This service can also be provided in the community.

This service is agency-directed and consumer-directed. Please refer to Exhibit A for an overview of the consumer-directed model of this service.

___ Other service definition (Specify):
FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

XX Individual's home or place of residence (agency- and consumer-directed models)

___ Foster home

___ Medicaid certified Hospital

XX Medicaid certified NF--services provided by staff of NF (agency-directed model only)

___ Medicaid certified ICF/MR

___ Group home

XX Licensed respite care facility--services provided by staff of licensed respite care facility (agency-directed model only)

___ Other community care residential facility approved by the State that it's not a private residence (Specify type):

___ Other service definition (Specify):

f. XX Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

XX Other service definition (Specify):
Services furnished 6 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care may be furnished at the adult day health care center, but is not furnished as a component part of this service.

Transportation between the individual's place of residence and the adult day health center will not be provided as a component part of adult day health services. If the adult day health care provider wishes to and is able to provide transportation services to the recipient, DMAS may reimburse the provider for these services.

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.___ Habilitation:

___ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an

adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to

habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver

services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.___Yes 2.___No

___ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to

prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.____ Environmental accessibility adaptations:

___ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

___ Other service definition (Specify):

i.____ Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j.____ Transportation:

___ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k.____ Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily

living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l.___ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m. XX Personal Emergency Response Systems (PERS)

XX PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services are also limited to those recipients, ages 14 and older. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance.

____ Other service definition (Specify):

n.___ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.___ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function,

and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

____ Other service definition (Specify):

1. Services provided by family members (Check one):

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse. Justification attached. (Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual; and there must be objective written documentation as to why there are no other providers available to provide the service.

2. Supervision of personal care providers will be furnished by (Check all that apply):

____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

r.____ Adult Residential Care (Check all that apply):

_____Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including

persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed____). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision

and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care
___ Physical therapy
___ Occupational therapy
___ Speech therapy
___ Medication administration
___ Intermittent skilled nursing services
___ Transportation specified in the plan of care
___ Periodic nursing evaluations
___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s._____Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

t.____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services
___ Home health care services
___ Physical therapy services
___ Occupational therapy services
___ Speech, hearing and language services
___ Prescribed drugs
___ Other State plan services (Specify):

u.____ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
d. drugs and biologicals furnished for therapeutic purposes,
e. individual activity therapies that are not primarily recreational or diversionary,
f. family counseling (the primary purpose of which is treatment of the individual's condition),
g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
b. social skills training in appropriate use of community services;
c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,
b. prevocational services,
c. supported employment services, and
d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

Exhibit A

Overview of Consumer-Direction in the Elderly or Disabled with Consumer-Direction Waiver

Consumer-Directed Services

The Elderly or Disabled with Consumer-Direction Waiver offers consumer-directed models of service delivery for personal assistance and respite care in addition to the traditional agency-directed model of service delivery. Consumer-direction for these services means that the individual is the employer; the individual is responsible for hiring, training, supervising, and firing consumer-directed employees. If the individual is a minor, or unable to handle the responsibilities related to being an employer, a family/caregiver may assume these responsibilities on behalf of the individual. Specific employer duties include checking potential employee references, determining that the potential employee meet the provider qualifications, submitting employee completed paperwork to the fiscal agent, training the employee, supervising the employee's performance, and confirming/submitting the employee's timesheets to the fiscal agent. The individual must have a viable back-up plan in the event the employee cannot work for whatever reason. Individuals who do not have a viable back-up plan are not eligible for this service delivery option. Qualifications of consumer-directed employees are described in Exhibit C.

Supervision of the consumer-directed employee is furnished directly by the individual or the family/caregiver with consultation by the consumer-directed (CD) Service Facilitator as needed. The individual or family/caregiver, upon entry into the service, will receive management training by the CD Service Facilitator. During visits with the individual, the CD Service Facilitator must observe, evaluate, and consult with the individual or family/caregiver, and document the adequacy and appropriateness of consumer-directed services with regard to the individual's current functioning and cognitive status, medical and social needs. CD Service Facilitator requirements are described in Exhibit B.

Service Facilitation

Service Facilitation is an administrative function that is available through the Elderly or Disabled with Consumer-Direction Waiver for individuals who choose to use the consumer directed service delivery model. A CD Service Facilitator assists the individual and/or family/caregiver as they become employers for consumer directed services. This function includes providing the individual and/or family/caregiver with management training, review and explanation of the Employee Management Manual, development of the plan of care, and routine visits to monitor the employment process. A consumer-directed employee registry is maintained by the CD Service Facilitator to assist with the recruitment process if needed. The CD Service Facilitator assists the individual with submitting required paperwork to the fiscal agent so the individual is formally considered the "employer."

The CD Service Facilitator assists with the initiation of consumer-directed services by completing a criminal record check on the potential employee (and a Child Protective Services screening if appropriate) and reporting the results to the employer and the fiscal agent. The CD Service Facilitator reviews the employee timesheets during face-to-face visits every six months for respite and quarterly for personal assistance to ensure the services are delivered as required in the approved plan of care. Discrepancies are addressed and resolved with the individual and/or family/caregiver and reported to the fiscal agent as needed. The CD Service Facilitator assists the individual/employer with training the consumer directed employee, or may train the employee on behalf of the individual/employer. The CD Service Facilitator monitors the employment process and works with the individual/employer on employer issues as they arise.

CD Service Facilitators must maintain certain records per DMAS requirements.

Fiscal Agent

DMAS serves as the fiscal agent and, as such, provides an administrative function for individuals who choose to use the consumer-directed service delivery model. Having a fiscal agent recognized by the IRS, allows the individual to participate in consumer directed services while being assured that all employment tax responsibilities are properly handled. This function includes taking appropriate actions to file/register the individual as an employer. The fiscal agent conducts payroll activities for the consumer-directed employee on behalf of the individual/employer. Employee timesheets are submitted to the fiscal agent by the individual/employer for payment. The fiscal agent prepares reports and maintains records as required.

Administration

Services under this option will be administered as follows:

- Upon being approved for this service as part of the individual's plan of care, the individual or family/caregiver will receive management training by the CD Service Facilitator to instruct them on how to hire, supervise, and fire assistants.
- The CD Service Facilitator assists with the initiation of services, the development of an individualized plan of care, which addresses the individual's needs at home, work, and/or in the community. The CD Service Facilitator also provides oversight of consumer-directed services. The CD Service Facilitator will periodically review the utilization of this service.
- The individual or family/caregiver will select and train an assistant to render consumer-directed assistance services. The individual or family/caregiver will have the assistant fill out employment paperwork and submit the forms to the CD assistance service's fiscal agent.
- When the service is rendered, the timesheet is signed by the assistant and the individual or family/caregiver, who then submits it to the fiscal agent, indicating that service was rendered satisfactorily.
- The fiscal agent pays the assistant on behalf of the individual and invoices DMAS for the consumer-directed assistance care costs.

- Supervision of the assistant will be furnished directly by the individual or the family caregiver with consultation by the CD Service Facilitator. The provision of care by the assistant will be observed by the CD Service Facilitator, and the efficacy of consumer (individual, family/caregiver) provided supervision will be documented by the CD Service Facilitator.
- CD Service Facilitators will formally monitor the individuals' plans of care, review timesheets to ensure that the hours approved in the plans of care are not exceeded, submit criminal record checks on personal assistants on behalf of the individuals, be available to the individuals to assist in training of assistants and provide consultative support in personal assistance service delivery as needed to ensure the health, welfare, and safety of the individuals.
- DMAS, or an organization contracted with DMAS, functions as the fiscal agent for the individual; handling fiscal responsibilities on behalf of individuals receiving consumer-directed personal assistance services. The fiscal agent, which is recognized by the IRS to perform fiscal services on behalf of individuals, will assume all employment tax responsibilities.

An additional component to CD personal assistance services is work-related services. This service would extend the ability of the personal assistant to provide assistance in the workplace. Some services might include filing, retrieving work materials that are out of reach or providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment. This service would only be available to individuals who also require consumer-directed personal assistance services to meet their activities of daily living. Workplace supports through this waiver will not be provided if these services are available from the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act.

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Care (Agency Directed)	Personal Care Providers, Home Health Providers	12 VAC 5-380-10 et seq.	N/A	Exhibit D
Respite Care (Agency Directed)	Personal Care Providers, Home Health Providers, NFs, Respite Care Providers, Licensed Respite Care Facilities	12 VAC 5-380-10 et seq. NFs - Code of Virginia, 32.1-123 et seq.	N/A	Exhibit D
Adult Day Health Care	Adult Day Health Care Providers	22 VAC40-60-320	12VAC30-120-40 from current E&D Waiver regulations	N/A
Personal Emergency Response Systems (PERS)	DME Providers, PERS Providers (e.g., certified home health providers, hospitals)	N/A	N/A	Exhibit E
Consumer-Directed Personal Assistance Services	Personal Assistants, CD Service Facilitators	N/A	N/A	Exhibits B&C
Consumer-Directed Respite Services	Respite Assistants, CD Service Facilitators	N/A	N/A	Exhibits B&C

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply. When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

Exhibit B

Consumer-Directed Service Facilitator Qualifications for Consumer-Directed Personal Assistance and Respite Services

Consumer-Directed (CD) Service Facilitator Providers are:

- An agency, organization, or individual that enrolls with DMAS as a provider of CD Service Facilitation Services that are performed by CD Service Facilitators meeting the stated qualifications.

To be enrolled as a Medicaid CD Service Facilitation provider and maintain provider status, the following standards shall be met:

1. The agency must have sufficient qualified staff to perform the needed consumer directed service facilitation and support activities as required by the CD Respite, and/or CD Personal Assistance Services programs. The CD Service Facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. The CD Service Facilitator must have these knowledge, skills, and abilities at the entry level that must be documented or observable in the application form, or supporting documentation or in the interview (with appropriate documentation). The knowledge, skills, and abilities shall be, but not necessarily limited to:

    - Knowledge of:
        a. Types of functional limitation and health problems that may occur in persons who are elderly and/or disabled as well as strategies to reduce limitations and health problems;
        b. Physical assistance that may be required by people who are elderly and/or disabled, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
        c. Equipment and environmental modifications that may be required by people who are elderly and/or disabled which reduces the need for human help and improve safety;
        d. Various long-term care program requirements, including nursing facility placement criteria, Medicaid Waiver services, and other federal, state, and local resources that provide personal assistance, and respite services;
        e. DMAS CD Personal Assistance Services and CD Respite Care service program requirements, as well as the administrative duties for which the individual will be responsible;
        f. Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;
        g. Interviewing techniques;

h. The individual's right to make decisions about, direct the provisions of, and control his services, including hiring, training, managing, approving time sheets, and firing an assistant.
i. The principles of human behavior and interpersonal relationships; and
j. General principles of record documentation.

- Skills in:
    a. Negotiating with individual, family/caregivers and service providers;
    b. Observing, recording, and reporting behaviors;
    c. Identifying developing, and/or providing services to persons who are elderly and/or disabled; and
    d. Identifying services within the established services system to meet the individual's needs.

- Abilities to:
    a. Report findings of the assessment or onsite visit, either in writing or an alternate format for persons who have print impairments;
    b. Demonstrate a positive regard for individuals and their families;
    c. Be persistent and remain objective;
    d. Work independently, performing position duties under general supervision;
    e. Communicate effectively, verbally and in writing;
    f. Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and
    g. Interview.

Individuals meeting all the above qualifications may be considered a CD Service Facilitator; however, it is preferred that the CD Service Facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD Service Facilitator have two years of satisfactory experience in the human services field working with persons who are elderly and/or persons with disabilities.

2. If the CD Service Facilitation provider is not a Registered Nurse, the CD Service Facilitator must inform the primary health care provider (i.e., physician) that services are being provided and request consultation as needed.

Exhibit C

Consumer-Directed Personal Assistance and Respite Services Assistant Requirements

Individuals Who Are Employed by the Individual Under a Consumer-Directed Model of Care

Qualifications. The Assistant must:

- Be 18 years of age or older;
- Possess basic reading, writing, and math skills;
- Have a valid Social Security Number;
- Have the required skills to perform CD Personal Assistance or CD Respite services as specified in the individual's plan of care;
- Submit to a criminal history record check and submit to a record check under the State's Child Protective Services Registry. The personal assistant will not be compensated for services provided to the individual or family/caregiver after the records check verifies that the personal assistant has been convicted of crimes described in the Code of Virginia, § 37.1-183.3 and § 37.1-197.2; this assistant will also be terminated from employment.
- Be willing to attend a training (i.e., safety training) at the individual or family/caregiver's request;
- Receive periodic TB screening, CPR training, and an annual flu immunization (unless medically contraindicated); and
- Understand and agree to comply with the CD Personal Assistance Services and CD Respite Service requirements.

Personal assistants shall not be spouses or parents of minor children.

Exhibit D

Personal/Respite Care Agency Provider Requirements

All personal/respite care providers must have a current participation agreement with DMAS to provide personal assistance/respite services.

Personal Assistance/Respite services may be provided by the following type of provider:

1. Enrolled by DMAS as a Personal Care Provider agency.

   Individuals who provide services must meet the requirements of DMAS Personal/Respite Care Assistant. Basic qualifications for Personal/Respite Assistants include the:

   - Physical ability to do the work;
   - Ability to read and write;
   - Completion of a training curriculum consistent with DMAS requirements. Prior to assigning an assistant to a consumer, the provider agency must obtain documentation that the assistant has satisfactorily completed a training program consistent with DMAS requirements. DMAS requirements may be met in one of three ways:

     a. Registration as Certified Nurse Assistant; or

     b. Graduation from an approved educational curriculum which offers certificates qualifying the student as a Nursing Assistant, Geriatric Assistant, or Home Health Assistant; or

     c. Provider-offered training, which must receive prior approval from DMAS.

DMAS will not contract directly with individuals to provide Personal Assistance or Respite services. Personal Assistance and Respite service providers may be related to an individual, but may not be spouses or parents of minor children. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the assistant qualifications.

Exhibit E
Personal Emergency Response Provider Requirements

PERS is a service which electronically monitors individual safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices.

PERS can be authorized when there is no one, other than the individual, in the home who is competent and continuously available to call for help in an emergency. If the individual's caregiver has a business in the home, such as a day care center, PERS will only be approved if the individual is evaluated as being dependent in orientation and behavior pattern. Medication monitoring units must be physician ordered and are not considered a stand-alone service; individuals must be receiving PERS services and medication monitoring services simultaneously. In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

A PERS provider may be a certified home health or personal care agency, a long-term home health care program, a hospital, or any other entity capable of providing PERS services either directly or through subcontracts.

A PERS provider may also be a monitoring agency that is capable of receiving signals for help from a individual's PERS equipment 24 hours a day, seven days per week; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

A PERS provider must comply with all applicable Virginia Statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

The PERS provider has the primary responsibility to furnish, install, maintain, test and service the PERS equipment as required, as well as to appropriately respond to signals for help.

- The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line and must furnish all supplies necessary for installing this equipment.
- A PERS provider must maintain all installed PERS equipment in proper working order.
- A PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS.
- The PERS provider must provide an emergency response center staffed with trained emergency response operators available on a 24-hour basis, 365 days per

year. The PERS provider must ensure that the monitoring agency is able to respond to the individual when a individual signals for help.

Standards for PERS Equipment. All PERS equipment must be approved by the Federal Communications Commission and the Underwriters' Laboratories, Inc. (UL) safety standard Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The equipment shall be waterproof and be able to be worn by the individual.

The emergency response activator must be activated either by breath, by touch, or by some other means and must be useable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.

Standards for Monitoring Agencies. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to assure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the individuals' PERS equipment. The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures. The agency must ensure 24 hour staffing of the monitoring agency and ensure that monitoring agency staff are fully trained regarding their responsibilities when the monitoring agency receives signals for help from a patient's PERS equipment. The monitoring agency staff will pass a written test administered by the provider pertaining to proper operation of the system and response to emergencies prior to being assigned to the agency.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

XX A copy of the standards applicable to each type of facility identified below is maintained by the Medicaid agency.

(1) Nursing facilities (Code of Virginia, 32.1-123 et seq., 12VAC30-10-631, and 12VAC30-60-40)
(2) Inpatient respite facility

APPENDIX C – ELIGIBILITY AND POST-ELIGIBLITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. XX Low income families with children as described in section 1931 of the Social Security Act.

2. _____ SSI recipients (SSI Criteria States and 1634 States).

3. XX Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. _____ Optional State supplement recipients

5. XX Optional categorically needy aged and disabled who have income at (Check one):

   a. ____ 100% of the Federal poverty level (FPL)

   b. 80 % of FPL which is lower than 100%.

6. XX The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   XX A. Yes ___ B. No

   Check one:

   a. XX ____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b._____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)___A special income level equal to:

_____300% of the SSI Federal benefit (FBR)

_____% of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2) XX_Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5) XX Aged and disabled who have income at:

a.____ 100% of the FPL

b. 80__% which is lower than 100%.

(6)____ All other mandatory and optional groups under the plan are included.

(7)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

_____

7.__XX Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8._____ All other mandatory and optional groups under the plan are included.

9._____Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2: POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and
community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. § 435.726--States which do not use more restrictive eligibility requirements than SSI.

a.____ Allowances for the needs of the

1. individual: (Check one):

A. The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):_____%

(5)___ Other (specify):

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A.___ SSI standard

B. Optional State supplement standard

C. Medically needy income standard

D.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ AFDC payment standard

C.___ Medically needy income standard

D.___ The following dollar amount: $_____*

*If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ___% of __ standard.

F.___ The amount is determined using the following formula:

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) XX 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:____%

(5)___ Other (specify):

B.___ The following dollar amount: $____*

* If this amount changes, this item will be revised.

C. XX The following formula is used to determine the amount:

The basic maintenance needs for an individual is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300% SSI; for an individual employed at least 8 but less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added

to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under §435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.____The following percentage of the following standard that is not greater than the standards above:____% of

D. The following formula is used to determine the amount:

F._XX_ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ AFDC payment standard

C._XX_ Medically needy income standard

D.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F.___ The following formula is used to determine the amount:

G.____ Not applicable (N/A)

(b). Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. XX The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(1)____Institutional PNA: Specify the amount: $_____

* Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community:

(2) XX An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipient who have no community spouses: (check one)

(a)____SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:____%

(spouse)_____ Other (specify):

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f) XX The following formula is used to determine the needs allowance:

The basic maintenance needs for an individual is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 300%

SSI; for an individual employed at least 8 but less than 20 hours per week, earned and unearned income shall be disregarded up to a maximum of both earned and unearned income up to 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_XX Other (Specify): The initial evaluation of level of care will be performed by the current Pre-Admission Screening (PAS) Teams that perform the authorization for nursing home and DMAS Home and Community Based Care waiver programs whose alternative institutional placement is a nursing facility. These teams include:

1. Acute care pre-admission screening teams consisting of nurses or social workers and physicians; or

2. Community-based teams, which include a Department of Social Services social worker, the Department of Health nurse, and a physician.

The procedures for evaluating and authorizing waiver services is the same as nursing facility. Each screener will assess the individual's needs with the Uniform Assessment Instrument (Exhibit F), and for CD services, additional questions (Exhibit G) to determine the individual's ability to manage CD services; apply the level of care criteria and authorize the appropriate level of care of services. DMAS or the preauthorization agent will review each authorization for services for accuracy, completeness and adherence to policies and procedures.

DMAS reviews a random sample of the evaluations made by the preauthorization agent.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months
XX Every 6 months
XX Every 12 months
___ Other (Specify):

Service Provider Reevaluation. Every service provider is required, every six months, to conduct a reassessment of the individual's level of care and appropriateness of the plan of care. This ongoing reassessment is documented in the agency file for that individual.

DMAS Reevaluations

DMAS staff members are assigned to perform level of care reevaluations pursuant to 42CFR §441.302. DMAS will ensure that individuals continue to meet the criteria for the waiver. This review is based on the documentation submitted by the provider. If there are any questions about the documentation submitted, DMAS staff will follow-up with the provider. If necessary, DMAS staff will make a home visit to personally evaluate the individual.

Level of care is also reviewed during utilization review visits.

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

___ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

XX The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)
XX Registered Nurse, licensed in the State
XX Licensed Social Worker
____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
XX Other (Specify):

The persons who perform reevaluations of level of care must meet one of the qualifications listed above or be an individual who holds at least a bachelor's degree in social

work or in a human services field (including, but not limited to: sociology, rehabilitation counseling, or psychology). If the person does not have a bachelor's degree, he or she must have at least two years of experience working directly with individuals who are elderly and/or disabled.

In the ADHC, the Director (if the Director meets the required qualifications), Registered Nurse or Therapist is responsible for completing the reevaluations.

For CD Services, the persons who perform reevaluations of level of care must meet one of the qualifications as identified in Exhibit B for CD Service Facilitators.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

XX Edits in computer system (Level of Care Access Database)

___ Component part of case management

XX Other (Specify): Component part of CD service facilitation and personal/respite services provided by agencies.

Exhibit F

Uniform Assessment Instrument

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen ____/____/____
Assessment ____/____/____
Reassessment ____/____/____

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ **Client SSN:** ___-___-____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: ( ) _____ **City/County Code:** _____ _____ _____

Directions to House:

Pets?

Demographics

Birthdate: ____/____/____ **Age:** _____ **Sex:** ___ Male 0 ___ Female 1
(Month) (Day) (Year)

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify _____

Communication of Needs:
___ Verbally, English 0
___ Verbally, Other Language 1
Specify _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

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CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	**Provider/Frequency:**
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
___	___	Other _____	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit. _____

Optional. Total monthly family income _____

Do you currently receive income from . . . ?

No 0	Yes 1	*Optional Amount*
___	___	Black Lung, _____
___	___	Pension, _____
___	___	Social Security, _____
___	___	SSI/SSDI, _____
___	___	VA Benefits, _____
___	___	Wages/Salary, _____
___	___	Other, _____

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	*Names*
___	___	Legal Guardian, _____
___	___	Power of Attorney, _____
___	___	Representative Payee, _____
___	___	Other, _____

Do you receive any benefits or entitlements?

No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
___	___	Medicare, # _____
___	___	Medicaid, # _____
		Pending ☐ No 0 ☐ Yes 1
		QMB/SLMB ☐ No 0 ☐ Yes 1
___	___	All Other Public/Private _____

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CLIENT NAME:	Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House Own 0				
___ House Rent 1				
___ House Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

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CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help D		MH & HH 3 D		Performed by Others 40 D			Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent D Weekly or more 3	External Device D Not self care 4	Indwelling Catheter D Not self care 5	Ostomy D Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help D		MH & HH 3 D		Performed by Others 40 D	Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ◆ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

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CLIENT NAME:	Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		*Location*
___	___	Living Will,	
___	___	Durable Power of Attorney for Health Care,	
___	___	Other,	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ____ None 00 ____ DX1 ____ DX2 ____ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8			
9			
10.			

Total No. of Medications: ____ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** ____

Do you have any problems with medicine(s) . . . ?

No 0	Yes 1	
___	___	Adverse reactions/allergies
___	___	Cost of medication
___	___	Getting to the pharmacy
___	___	Taking them as instructed/prescribed
___	___	Understanding directions/schedule

How do you take your medicine(s)?

- ___ Without assistance 0
- ___ Administered/monitored by lay person 1
- ___ Administered/monitored by professional nursing staff 2

Describe help ____

Name of helper ____

Diagnoses:

- **Alcoholism/Substance Abuse (01)**
- **Blood-Related Problems (02)**
- **Cancer (03)**
- **Cardiovascular Problems**
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- **Dementia**
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- **Developmental Disabilities**
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- **Digestive/Liver/Gall Bladder (18)**
- **Endocrine (Gland) Problems**
  - Diabetes (19)
  - Other Endocrine Problems (20)
- **Eye Disorders (21)**
- **Immune System Disorders (22)**
- **Muscular/Skeletal**
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- **Neurological Problems**
  - Brain Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- **Psychiatric Problems**
  - Anxiety Disorders (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- **Respiratory Problems**
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- **Urinary/Reproductive Problems**
  - Renal Failure (40)
  - Other Urinary/Reproductive Problems (41)
- **All Other Problems (42)**

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CLIENT NAME:	Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ **No** 0 ___ **Yes** 1

Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

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CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		Frequency
___	___	Occupational	
___	___	Physical	
___	___	Reality/Remotivation	
___	___	Respiratory	
___	___	Speech	
___	___	Other	

Do you have any pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		Site, Type, Frequency
___	___	Bowel/Bladder Training	
___	___	Dialysis	
___	___	Dressing/Wound Care	
___	___	Eyecare	
___	___	Glucose/Blood Sugar	
___	___	Injections/IV Therapy	
___	___	Oxygen	
___	___	Radiation/Chemotherapy	
___	___	Restraints (Physical/Chemical)	
___	___	ROM Exercise	
___	___	Trach Care/Suctioning	
___	___	Ventilator	
___	___	Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

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CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

Time: **Would you tell me the date today** *(year, season, date, day, month)?*

___ Oriented 0

___ Disoriented - Some spheres, some of the time 1

___ Disoriented - Some spheres, all the time 2

___ Disoriented - All spheres, some of the time 3

___ Disoriented - All spheres, all of the time 4

___ Comatose 5

Spheres affected: _____

_____

Optional: **MMSE Score**

_____ (5)

_____ (5)

_____ (3)

_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0	Yes 1	
___	___	Short -Term Memory Loss?
___	___	Long-Term Memory Loss?
___	___	Judgement Problem?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0

___ Wandering/Passive - Less than weekly 1

___ Wandering/Passive - Weekly or more 2

___ Abusive/Aggressive/Disruptive - Less than weekly 3

___ Abusive/Aggressive/Disruptive - Weekly or more 4

___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

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CLIENT NAME:	Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0	Yes 1		*Describe*
___	___	Solitary Activities,	_____
___	___	With Friends/Family,	_____
___	___	With Groups/Clubs,	_____
___	___	Religious Activities,	_____

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children

- ___ No Children 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Other Family

- ___ No Other Family 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Friends/Neighbors

- ___ No Friends/Neighbors 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ **No** 0 ___ **Yes** 1

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CLIENT NAME:	Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1

Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1

___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1

___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

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CLIENT NAME:	Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

_____

_____

Family/Representative's preferences for client's care: _____

_____

_____

Physician's comments (if applicable): _____

_____

_____

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CLIENT NAME:	Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)
___	___	Finances
___	___	Home/Physical Environment
___	___	ADLS
___	___	IADLS

No 0	Yes 1	(Check All That Apply)
___	___	Assistive Devices/Medical Equipment
___	___	Medical Care/Health
___	___	Nutrition
___	___	Cognitive/Emotional
___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____

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Exhibit G

Additional Questions to Determine the Individual's Ability to Manage CD Services

Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services:

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Attendant Services in The Consumer-Directed Personal Attendant Services Waiver

To The Assessor: In addition to reviewing the applicant's ability to answer questions on the Uniform Assessment Instrument (UAI) regarding his or her status and care needs, question the applicant in the following areas and document the response. **Please note: applicants who have legal guardians or persons who serve as their committee are not eligible for Consumer-Directed Personal Attendant Services.**

· Daily Decision-Making

1. Did you pick out the clothes you are wearing? Please explain how you select what clothing you will wear for the day.

_____

_____

_____

2. How do you plan or arrange for your meals? What kinds of things do you eat for breakfast, lunch, and dinner?

_____

_____

_____

3. How do you manage your finances (pay your bills)?

_____

_____

_____

4. What do you do everyday? Please tell me your daily routine.

_____

_____

· Short- and Long-Range Planning

1. How often do you have to leave the house? If you do leave the house, how do you make appointments or schedule transportation? What transportation do you use?

_____

_____

Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services:
Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Attendant Services in The Consumer-Directed Personal Attendant Services Waiver (Continued)

Short- and Long-Range Planning (Continued)

2. How do you plan for a future event (for example, Christmas, family visits, etc?)

_____
_____
_____

Finding a Personal Attendant

1. How will you find and hire someone to be your personal attendant? What kind of person will you need to take care of your needs?

_____
_____
_____

2. How will you find a replacement if a personal attendant fails to come to work or quits without notice? How will you manage until you can find another attendant?

_____
_____
_____

3. What would you do to let someone know you needed assistance if your personal attendant does not show up?

_____
_____
_____

4. What steps would you take if your personal attendant was abusive, or you thought the personal attendant was stealing from you?

_____
_____
_____

Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services:
Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Attendant Services in The Consumer-Directed Personal Attendant Services Waiver (Continued)

· Health Knowledge/Supports

1. What kind of medical problems do you have? How are you currently taking care of these needs (i.e., are you seeing a doctor?) If you needed to talk to someone about a medical problem, who would you call?

_____

_____

_____

_____

What kind of medications do you take and how often do you take them? What are they for?

_____

_____

_____

2. Who will be providing for your medical needs other than your personal attendant?

_____

_____

_____

· Support Network

1. Do you have additional support available from family, neighbors, friends, school or employers who can contact in case you have an emergency? If so, whom? How would you contact them?

_____

_____

_____

Applicant's Name: _____ Date: _____

The Virginia Department of Medical Assistance Services

Questionnaire To Assess An Applicant's Ability to Independently Manage Personal Attendant Services in The Consumer-Directed Personal Attendant Services Waiver (Continued)

Nursing Home Pre-Admission Screening Team Recommendation:

____ **I recommend the applicant receive Consumer-Directed Personal Attendant Services (PAS) based on: 1) The applicant's demonstrated ability to supervise a personal attendant; and/or 2) The applicant has adequate accommodations/support that enables him or her to manage services independently. The applicant will receive personal attendant management training prior to receiving Consumer-Directed PAS.**

Additional comments: _____

_____

(This section is applicable for applicants who are knowledgeable about their own care, can communicate their needs to a personal attendant, and understand the rights, risks, and responsibilities of Medicaid-Funded Consumer-Directed PAS. The applicant's responses to issues related to daily decision-making, short- and long-range planning, finding an assistant, health knowledge/supports, and support networks demonstrate that the applicant is capable of handling the responsibilities associated with Consumer-Directed PAS. Factors which should not influence this decision include, but are not limited to the inability to read and/or write due to a print impairment, educational level, the inability to communicate verbally, or the lack of previous experience in managing his or her health services.)

____ **I do not recommend the applicant receive Consumer-Directed PAS. The applicant has little or no knowledge of his or her care requirements and could not assume the responsibilities of consumer-directed personal attendant services at the present time. The applicant will be offered alternative Medicaid-funded long-term care options.**

Additional comments: _____

_____

(This section is applicable if the applicant has little or no knowledge of his or her care requirements or consumer-directed program responsibilities. Responses in the areas of daily decision-making, short- and long-range planning, finding a personal attendant, health knowledge/supports, or support networks given by the applicant do not demonstrate that the recipient would be capable of meeting program requirements of the consumer-directed personal attendant services and successfully managing PAS.)

Assessor Signature: _____ **Date:** _____

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

XX	By the Medicaid agency in its central office. All evaluation data is captured in a level of care access database.
___	By the Medicaid agency in district/local offices
___	By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
___	By the case managers
XX	By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
XX	By service providers
___	Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of **5** years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

The Virginia Uniform Assessment Instrument (Exhibit F) is the assessment document used in Virginia to assess and authorize for institutional and noninstitutional long-term care services. It is used for the initial evaluation of the individual's need for a level of care.

The DMAS-95 Addendum (Exhibit G) is a questionnaire to assess an applicants ability to independently manage CD services.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

XX The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
   a. informed of any feasible alternatives under the waiver; and
   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix (Exhibits H and I):
   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and;
   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

A copy of this form is maintained in the individual's record at the DMAS central office or at DMAS' preauthorization agent's office, in the individual's file in the provider agency and at the Pre-Admission Screening Team office.

Exhibit H

DRAFT

DOCUMENTATION OF RECIPIENT CHOICE BETWEEN INSTITUTIONAL CARE OR HOME AND COMMUNITY-BASED SERVICES

Recipient Name: _____

MAP: _____

The following has been presented and discussed with the recipient and, if applicable, the family member, parent, legal guardian or authorized representative *(please check all that apply)*:

- ❑ The findings and results of the recipient's evaluations and stated needs;
- ❑ A choice between Institutional Care (nursing facility) and the appropriate Home and Community Based Waiver;
- ❑ The recipient's right to a fair hearing and the appeal process.

The recipient and, if applicable, the family member, parent, legal guardian or authorized representative, has *(please select one option)*:

_____ selected Nursing Facility Services; OR

_____ selected Elderly or Disabled Consumer Direction Waiver Services; OR

_____ selected HIV/AIDS Waiver Services.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Family Member, Parent, Legal Guardian, Authorized Representative (underline applicable designation) Date

_____ _____
Signature of Screening Team Member Date

Exhibit I

VIRGINIA ELIGIBILITY AND APPEALS

Part I

Client Appeals

Subpart I
General

Article 1

Definitions

12VAC30-110-10. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Agency" means:

1. An agency which, on the department's behalf, makes determinations regarding applications for benefits provided by the department; and
2. The department itself.

"Appellant" means an applicant for or recipient of medical assistance benefits from the department who seeks to challenge an adverse action regarding his benefits or his eligibility for benefits.

"Department" means the Department of Medical Assistance Services.

"Division" means the department's Division of Client Appeals.

"Final decision" means a written determination by a hearing officer which is binding on the department, unless modified on appeal or review.

"Hearing" means the evidentiary hearing described in this regulation, conducted by a hearing officer employed by the department.

"Representative" means an attorney or agent who has been authorized to represent an appellant pursuant to these regulations.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.1; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment
The June 15, 1995, amendment deleted the definition of panel and effectively eliminated the availability of review by administrative law judges.

Article 2

The Appeal System

12VAC30-110-20. Division of Client Appeals.

The division maintains an appeals system for appellants to challenge adverse actions regarding services and benefits provided by the department. Appellants shall be entitled to a hearing before a hearing officer. See Subpart II of these regulations.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.2; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment

The June 15, 1995, amendment deleted (former) subdivision 2.

12VAC30-110-30. Time limitation for appeals.

Hearing officer appeals shall be scheduled and conducted to comply with the 90-day time limitation imposed by federal regulations, unless waived in writing by the appellant or the appellant's representative.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.3; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment
The June 15, 1995, amendment deleted a provision respecting final review.

12VAC30-110-40. Judicial review.

An appellant who believes a final decision as defined herein is incorrect may seek judicial review pursuant to § 9-6.14:1 et seq. of the Code of Virginia and Part 2A, Rules of the Virginia Supreme Court.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.4; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment
The June 15, 1995, amendment deleted the review and decision process of the Medical Assistance Appeals Panel.

Article 3
Representation

12VAC30-110-50. Right to representation.

An appellant shall have the full right to representation by an attorney or agent at all stages of appeal.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.5; eff. October 1, 1993.

12VAC30-110-60. Designation of representative.

A. Agents. An agent must be designated in a written statement which is signed by the appellant. If the appellant is physically or mentally unable to sign a written statement, the division may allow a family member or other person acting on appellant's behalf to represent the appellant.

B. Attorneys. If the agent is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead, shall be accepted as a designation of representation.

C. Substitution. A member of the same law firm as a designated representative shall have the same rights as the designated representative.

D. Revocation. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.6; eff. October 1, 1993.

Article 4
Notice and Appeal Rights

12VAC30-110-70. Notification of adverse agency action.

The agency which makes an initial adverse determination shall inform the applicant or recipient in a written notice:

1. What action the agency intends to take;
2. The reasons for the intended action;
3. The specific regulations that support or the change in law that requires the action;
4. The right to request an evidentiary hearing, and the methods and time limits for doing so;
5. The circumstances under which benefits are continued if a hearing is requested (see 12VAC30-110-100); and
6. The right to representation.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.7; eff. October 1, 1993.

12VAC30-110-80. Advance notice.

When the agency plans to terminate, suspend or reduce an individual's eligibility or covered services, the agency must mail the notice described in 12VAC30-110-70 at least 10 days before the date of action, except as otherwise permitted by federal law.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.8; eff. October 1, 1993.

12VAC30-110-90. Right to appeal.

An individual has the right to file an appeal when:

1. His application for benefits administered by the department is denied. However, if an application for State Local Hospitalization coverage is denied because of a lack of funds which is confirmed by the hearing officer, there is no right to appeal.
2. The agency takes action or proposes to take action which will adversely affect, reduce, or terminate his receipt of benefits;
3. His request for a particular medical service is denied, in whole or in part;
4. The agency does not act with reasonable promptness on his application for benefits or request for a particular medical service; or
5. Federal regulations require that a fair hearing be granted.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.9; eff. October 1, 1993.

12VAC30-110-100. Maintaining services.

A. If the agency mails the 10-day notice described in 12VAC30-110-80 and the appellant files his Request for Appeal before the date of action, his services shall not be terminated or reduced until the hearing officer issues a final decision unless it is determined at the hearing that the sole issue is one of federal or state law or policy and the appellant is promptly informed in writing that services are to be terminated or reduced pending the final decision.

B. If the agency's action is sustained on appeal, the agency may institute any available recovery procedures against the appellant to recoup the cost of any services furnished to the appellant, to the extent they were furnished solely by reason of subsection A of this section.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.10; eff. October 1, 1993.

Article 5
Miscellaneous Provisions

12VAC30-110-110. Division records.

A. Removal of records. No person shall take from the division's custody any original record, paper, document, or exhibit which has been certified to the division except as the Director of Client Appeals authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Confidentiality of records. Information in the appellant's record can be released only to a properly designated representative or other person(s) named in a release of information authorization signed by an appellant, his guardian or power of attorney.

C. Fees. The fees to be charged and collected for any copies will be in accordance with Virginia's Freedom of Information Act or other controlling law.

D. Waiver of fees. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an individual's own review or appeal.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.11; eff. October 1, 1993.

12VAC30-110-120. Computation of time limits.

A. Acceptance of postmark date. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

B. Computation of time limit. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 1.12; eff. October 1, 1993.

Subpart II

Hearing Officer Review

Article 1

Commencement of Appeals

12VAC30-110-130. Request for appeal.

Any written communication from an appellant or his representative which clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request. This communication should explain the basis for the appeal.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.1; eff. October 1, 1993.

12VAC30-110-140. Place of filing a Request for Appeal.

A Request for Appeal shall be delivered or mailed to the Division of Client Appeals.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.2; eff. October 1, 1993.

12VAC30-110-150. Filing date.

The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.3; eff. October 1, 1993.

12VAC30-110-160. Time limit for filing.

A Request for Appeal shall be filed within 30 days of the appellant's receipt of the notice of an adverse action described in 12VAC30-110-70. It is presumed that appellants will receive the notice three days after the agency mails the notice. A Request for Appeal on the grounds that an agency has not acted with reasonable promptness may be filed at any time until the agency has acted.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.4; eff. October 1, 1993.

12VAC30-110-170. Extension of time for filing.

An extension of the 30-day period for filing a Request for Appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. Appellant was seriously ill and was prevented from contacting the division;
2. Appellant did not receive notice of the agency's decision;
3. Appellant sent the Request for Appeal to another government agency in good faith within the time limit;
4. Unusual or unavoidable circumstances prevented a timely filing.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.5; eff. October 1, 1993.

12VAC30-110-180. Provision of information.

Upon receipt of a Request for Appeal, the division shall notify the appellant and his representative of general appeals procedures and shall provide further detailed information upon request.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.6; eff. October 1, 1993.

Article 2
Prehearing Review

12VAC30-110-190. Review.

A hearing officer shall initially review an assigned case for compliance with prehearing requirements and may communicate with the appellant or his representative and the agency to confirm the agency action and schedule the hearing.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.7; eff. October 1, 1993.

12VAC30-110-200. Medical assessment.

A. A hearing officer may order an independent medical assessment when:

1. The hearing involves medical issues such as a diagnosis, an examining physician's report, or a medical review team's decision; and
2. The hearing officer determines it necessary to have an assessment by someone other than the person or team who made the original decision, for example, to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence.

B. A medical assessment ordered pursuant to this regulation shall be at the department's expense and shall become part of the record.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.8; eff. October 1, 1993.

12VAC30-110-210. Prehearing action.

A. Invalidation. A Request for Appeal may be invalidated if it was not filed within the time limit imposed by 12VAC30-110-160 or extended pursuant to 12VAC30-110-170.

1. If the hearing officer determines that the appellant has failed to file a timely appeal, the hearing officer shall notify the appellant and the appellant's representative of the opportunity to show good cause for the late appeal.

2. If a factual dispute exists about the timeliness of the Request for Appeal, the hearing officer shall receive evidence or testimony on those matters before taking final action.

3. If the individual filing the appeal is not the appellant or an authorized representative of the appellant under the provisions of 12VAC30-110-60 A, the appeal shall be determined invalid.

4. If a Request for Appeal is invalidated, the hearing officer shall issue a decision pursuant to 12VAC30-110-370.

B. Administrative dismissal. Request for Appeal may be administratively dismissed without a hearing if the appellant has no right to appeal under 12VAC30-110-90.

1. If the hearing officer determines that the appellant does not have the right to an appeal, the hearing officer shall issue a final decision dismissing the appeal and notify the appellant and appellant's representative of the opportunity to seek judicial review.

2. If a Request for Appeal is administratively dismissed, the hearing officer shall issue a decision pursuant to 12VAC30-110-370.

C. Judgment on the record. If the hearing officer determines from the record that the agency's determination was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a decision pursuant to 12VAC30-110-370.

D. Remand to agency. If the hearing officer determines from the record that the case might be resolved in the appellant's favor if the agency obtains and develops additional information, documentation, or verification, he may remand the case to the agency for action consistent with the hearing officer's written instructions. The remand order shall be sent to the appellant and any representative.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.9; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment
The June 15, 1995, amendment deleted subsection E governing removal to the Medical Assistance Panel.

Article 3
Hearing

12VAC30-110-220. Evidentiary hearings.

A hearing officer shall review all agency determinations which are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; and issue a written final decision sustaining, reversing, or remanding each case to the agency for further proceedings.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.10; eff. October 1, 1993.

12VAC30-110-230. Scheduling and rescheduling.

A. To the extent possible, hearings will be scheduled at the appellant's convenience, with consideration of the travel distance required.

B. A hearing shall be rescheduled at the claimant's request no more than twice unless compelling reasons exist.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.11; eff. October 1, 1993; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Effect of Amendment
The June 15, 1995, amendment designated subsection A and added subsection B, former 12VAC30-110-240.

12VAC30-110-240. [Repealed]

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.11.1; eff. October 1, 1993; repealed, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

Editor's Note
The provisions of former 12VAC30-110-240 now appear in 12VAC30-110-230 B.

12VAC30-110-250. Notification.

When a hearing is scheduled, the appellant and his representative shall be notified in writing of its time and place.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.12; eff. October 1, 1993.

12VAC30-110-260. Postponement.

A hearing may be postponed for good cause shown. No postponement will be granted beyond 30 days after the date of the Request for Appeal was filed unless the appellant or his representative waives in writing the 90-day deadline for the final decision.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.13; eff. October 1, 1993.

12VAC30-110-270. Location.

The hearing location shall be determined by the division. If for medical reasons the appellant is unable to travel, the hearing may be conducted at his residence.

The agency may respond to a series of individual requests for hearings by conducting a single group hearing:

1. Only in cases in which the sole issue involved is one of federal or state law or policy; and

2. Each person must be permitted to present his own case or be represented by his authorized representative.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.14; eff. October 1, 1993.

12VAC30-110-280. Client access to records.

Upon the request of the appellant or his representative, at a reasonable time before the date of the hearing, as well as during the hearing, the appellant and his representative may examine the content of appellant's case file and all documents and records the agency will rely on at the hearing.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.15; eff. October 1, 1993.

12VAC30-110-290. Subpoenas.

Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request issuance of a subpoena in writing. The request must be received by the division at least five business days before the hearing is scheduled. Such request must include the witness' name, home and work address, county or city of work and residence, and identify the sheriff's office which will serve the subpoena.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.16; eff. October 1, 1993.

12VAC30-110-300. Role of the hearing officer.

The hearing officer shall conduct the hearing, decide on questions of evidence, procedure and law, question witnesses, and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.17; eff. October 1, 1993; amended, Virginia Register Volume 10, Issue 23, eff. October 1, 1994.

12VAC30-110-310. Informality of hearings.

Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative has the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.18; eff. October 1, 1993.

12VAC30-110-320. Evidence.

The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.19; eff. October 1, 1993.

12VAC30-110-330. Record of hearing.

All hearings shall be recorded either by court reporter, tape recorders, or whatever other means the agency deems appropriate. All exhibits accepted or rejected shall become part of the hearing record.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.20; eff. October 1, 1993.

12VAC30-110-340. Oath or affirmation.

All witnesses shall testify under oath which shall be administered by the court reporter or the hearing officer, as delegated by the department's director.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.21; eff. October 1, 1993.

12VAC30-110-350. Dismissal of Request for Appeal.

Request for Appeal may be dismissed if:

1. The appellant or his representative withdraws the request in writing; or

2. The appellant or his representative fails to appear at the scheduled hearing without good cause, and does not reply within 10 days after the hearing officer mails an inquiry as to whether the appellant wishes further action on the appeal.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.22; eff. October 1, 1993.

12VAC30-110-360. Post-hearing supplementation of the record.

A. Medical assessment. Following a hearing, a hearing officer may order an independent medical assessment as described in 12VAC30-110-200.

B. Additional evidence. The hearing officer may leave the hearing record opened for a specified period of time in order to receive additional evidence or argument from the appellant. If the record indicates that evidence exists which was not presented by either party, with the appellant's permission, the hearing officer may attempt to secure such evidence.

C. Appellant's right to reconvene hearing or comment. If the hearing officer receives additional evidence from a person other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative and give the appellant the opportunity to comment on such evidence in writing or to reconvene the hearing to respond to such evidence.

D. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.23; eff. October 1, 1993.

12VAC30-110-370. Final decision.

After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision which either sustains or reverses the agency action or remands the case to the agency for further action consistent with his written instructions. The hearing officer's final decision shall be considered as the agency's final administrative action pursuant to 42 CFR, 431.244(f). The final decision shall include:

1. A description of the procedural development of the case;
2. Findings of fact which identify supporting evidence;
3. Conclusions of law which identify supporting regulations and law;
4. Conclusions and reasoning;
5. The specific action to be taken by the agency to implement the decision; and
6. The notice shall state that a final decision may be appealed directly to circuit court as provided in § 9-6.14:16 B of the Code of Virginia and 12VAC30-110-40.

Statutory Authority
§§ 32.1-324 and 32.1-325 of the Code of Virginia.

Historical Notes
Derived from VR460-04-8.7 § 2.24; eff. October 1, 1993; amended, Virginia Register Volume 10, Issue 23, eff. October 1, 1994; amended, Virginia Register Volume 11, Issue 17, eff. June 15, 1995.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

XX Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

XX Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

___ Case Manager

XX Other (specify): In the ADHC, the Director (if the Director meets the required qualifications), Registered Nurse or Therapist is responsible for completing the plan of care.

For CD Services the Service Facilitator is responsible for the preparation of the plans of care.

2. Copies of written plans of care will be maintained for a minimum period of 5 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

___ By case managers

___ By the agency specified in Appendix A

XX By consumers (for informational purposes only; will not be required to keep for five years).

XX Other (specify): For CD services, the Service Facilitator. For agency directed services, the service provider. Will also be kept by the preauthorization agent.

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

XX Every 6 months

___ Every 12 months

___ Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The following process is the same for both agency-directed and consumer-directed services. The assessment, authorization, and pre-admission screening service plan is submitted to DMAS or DMAS' preauthorization agent for approval prior to any provider's ability to bill for services. DMAS or DMAS' preauthorization agent must approve plans of care in accordance with policies developed for persons who meet the waiver's target population. Upon approval of the plan of care, DMAS or DMAS' preauthorization agent enters the individual's approved services into the Medicaid Management Information System (MMIS), which is developed and maintained by DMAS, and the preauthorization agent's database to allow only those services which have been authorized and are within the limits and scope of service coverage allowed by DMAS. DMAS routinely monitors reports generated by the MMIS and the preauthorization agent's database to assure that plans of care are appropriate. In addition, a contract monitor is assigned to review the DMAS' preauthorization agent's files for accuracy.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. Copies of the plan of care forms (for agency directed and consumer directed services) to be utilized in this waiver are attached to this Appendix (Exhibit J).

Exhibit J

Plans of Care

PROVIDER AGENCY PLAN OF CARE

Recipient Name: _____ Medicaid ID#: _____

Provider Agency: _____ Provider ID#: _____

FOR EACH TASK TO BE DONE, ENTER TIME FOR EACH CATEGORY AND ADD FOR TOTAL TIME

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADLS's Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
TIME:							
2. Special Maintenance Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder Program							
Time:							
3. Supervision Time							
4. Housekeeping Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Recipient							
Shop/List Supplies							
Laundry							
Work/School/ Social							
IADLS Time:							
Total Daily Time:							

Composite ADL Score = (The sum of the ADL ratings that describe this recipient.)

BATHING SCORE

Bathes without help or with MH only	0
Bathes with HH or with HH & MH	1
Is Bathed	2

DRESSING SCORE

Dress without help or with MH only	0
Dresses with HH or with HH & MH	1
Is dressed or does not dress	2

AMBULATION SCORE

Walks/Wheels without help/ w/MH only	0
Walks/Wheels w/ HH or HH & MH	1
Totally Dependent for mobility	2

TRANSFERRING SCORE

Transfers without help or with MH only	0
Transfers w/ HH or w/HH & MH	1
Is Transferred or does not transfer	2

EATING SCORE

Eats without help or with MH only	0
Eats with HH or HH & MH	1
Is fed: Spoon/tube/etc.	2

CONTINENCY SCORE

Continent / incontinent < weekly self care of internal / external devices	0
Incontinent weekly or > Not self care	2

LEVEL OF CARE: (LOC)	**A** (Score 0 - 6) Maximum Hours of 25/Week	**B** (Score 7 - 12) Maximum Hours 30/Week	**C** (Score 9 + wounds, tube feedings, etc.) Maximum Hours 35/Week

The Amount of Time Needed to Complete All Tasks must Not Exceed The Maximum For the Specified LOC.

Reason Plan of Care Submitted: New Admission ? In Hours ? In Hours Transfer

Reason for change/Additional Instructions for the Aide: _____

Plan of Care Effective Date _____ Total Weekly Hours _____ RN Signature _____

DMAS-97A rev. 9/02

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, WVMI, 6802 Paragon Place, Suite 410, Richmond, Va. 23230. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ (effective date), and services may continue unchanged during the reconsideration process.

Instructions for Completion of the DMAS-97-A

Level of Care Determination For Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC.

Provider Notification To Client

Anytime the RN Supervisor changes the plan of care that results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require WVMI approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form.

WVMI Notification To Client

If the changes to the Plan of Care require WVMI approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to WVMI for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Once received by WVMI, the analyst will review the care plan and indicate whether the request is approved or denied. Once the decision is made, the DMAS-98 form will be sent back to the provider agency who is responsible for making sure the client receives a copy of the form which gives the client's right to appeal and the front of the care plan.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

_____ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

XX Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
   a. When the individual was eligible for Medicaid waiver payment on the date of service;
   b. When the service was included in the approved plan of care;
   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

____ Yes

XX No. These services are not included in this waiver.

DMAS assures that, when claims are paid, the individual is Medicaid-eligible at the time the services were rendered and the service being billed is an approved

service for that individual. DMAS also uses a post-payment review process to assure that services are approved and appropriate for the individual.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   XX All provider claims are processed through an approved MMIS.

   ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

   ____ The Medicaid agency will make payments directly to providers of waiver services.

   XX The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

   XX The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims for consumer-directed services.

   ____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

   Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.